



**TO BE COMPLETED BY PARENT OR GUARDIAN**

1. Please have an **adult** deliver the medication and completed form to the school.
2. Medication must be in its original container, labeled with the student's name, name of medication, dosage and include any necessary equipment for administration (e.g. spoon for liquid medication)
3. After the date for discontinuance of medication specified by the physician, changes to or continuance of the arrangements must be secured by filling out a newly dated copy of this form. All medication requests must be renewed each school year if continuation of the medication is necessary.
4. I understand that there is no school nurse on staff and I request that the coordinator or other designated personnel, administer the medication as directed by the physician on the front of this sheet. I understand that designated school personnel have my permission to communicate with the prescribing physician on matters related to this medication. I agree to save and hold the school, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

---

**PARENT OR GUARDIAN'S SIGNATURE**

---

**DATE**